Collins COUNSELING ASSOCIATES

1340 Sledge Drive
Mobile, AL 36606
251.473.3410
www.collinscounseling.org

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Client's Name: _____ Date of Birth: _____

AKA: _____ Social Security #: _____

I request and authorize Collins Counseling & Associates to release / obtain my healthcare information to / from:

Name: _____

Address: _____

_____

City: _____ State: _____ Zip Code: _____

Tel: _____ Fax: _____

This authorization applies to all information. I understand that the information may contain psychological, alcohol/drug abuse, AIDS/HIV information and/or other sensitive health information for all treatment dates, and I expressly consent to the release of all information.

To limit information disclosed, please specify:

_____

_____

_____

Client Signature: _____ Date Signed: _____

I understand the information released will be limited to information necessary to fulfill the need or purpose for the disclosure. If I have authorized the disclosure of information to a recipient who is not subject to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), then the recipient may re-disclose it and it may no longer be protected under HIPAA, a federal privacy law. This authorization is valid for ninety (90) days from the date of signature, unless otherwise noted. This authorization only applies to treatment occurring before the date of signature. I understand I may see and copy the information described on this form if I ask for it, and I may receive a copy of this form after I sign it. I represent that I have authority to and voluntarily grant permission for the information to be released and described above.

FAX RECORDS TO: (251) 476-4454